Exhibit 4

EXHIBIT 2 Kelly JD 8/20/19

PLEASE DO NOT DETACH

Foreign Medical Graduate Examination in the Medical Sciences and the ECFMG English Test

PART A

NOTE: All items on all sides of the application must be filled out completely for initial and repeat examinations or application will not be accepted. Use typewriter or block print in ink.

① EXAMINATION HISTORY:
Have you previously applied to take one or more of the examinations administered by ECFMG? ☐ Yes ☒ No
If you have been assigned an ECFMG Applicant Number, enter the number in this box. 482-700

② NAME: Print your name as you want it to appear on the Standard ECFMG Certificate
First Name: OLUWAFEMI Middle Name: CHARLES
Last Name (Surname): IGBERASE
Full Maiden Name (For married women only):

2.1 If you have previously applied to ECFMG under another name, provide that name
Previous Name:
Please include a copy of the legal document that verifies this name change.

③ ADDRESS: Use address to which admission permit and other notification from ECFMG should be sent
Number/Street: 9701 EVENING PRIMROSE DRIVE
Apartment Number: 2D
Post Office Box Number:
City: LAUREL
State/Country: MARYLAND
Zip or Postal Code: 20723

④ SOCIAL SECURITY NUMBER:
If you have a United States Social Security Number, enter the number in this box. 5054

⑤ STATUS OF MEDICAL SCHOOL STUDENT: *Must* be completed by students
If you are applying for Day 1, will you have completed two years of medical school by the date of that examination? ☐ Yes ☐ No
If you are applying for Day 2, will you have completed or be within 12 months of completion of the formal didactic curriculum at your medical school? ☐ Yes ☐ No

⑥ EXAMINATION REGISTRATION: Check ☒ box(es) to indicate the component(s) for which you are applying
Examination Date (Month/Year): JULY 1992
☒ Basic Medical Science Component (Day 1)
☒ Clinical Science Component *and* ECFMG English Test (Day 2)
☐ ECFMG English Test (administered on second day only)

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6.1 EXAMINATION CENTER: See ECFMG Information Booklet for list of centers
If you do not indicate a second choice of center and the first choice is *not* available, ECFMG reserves the right to assign a center.
Select two:
1st Choice: BALTIMORE (City) 300 (Center No.)
2nd Choice: WASHINGTON, D.C. (City) 350 (Center No.)

⑦ EXAMINATION FEE(S): Enter the amount enclosed on the line provided
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Fees must be paid in United States funds. Checks, bank drafts or money orders are to be made payable to the ECFMG. Do not send cash.

☐ Basic Medical Science Component (Day 1 only)	$265
Clinical Science Component *and* ECFMG English Test (Day 2 only)	$265
☒ Basic Medical Science Component, Clinical Science Component *and* ECFMG English Test (Day 1 and Day 2)	$425
ECFMG English Test only	$ 25

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Enter amount enclosed $ ____

 Form 104, FEB 1992

ECFMG-000155

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PART B

(8) SECONDARY SCHOOL COLLEGE/ UNIVERSITY:

Schools Attended	Location (exact address)	Dates Attended (month and year)	No. School Years
IMMACULATE CONCEPTION COLLEGE	BENIN CITY NIGERIA	JUNE 1974 SEPT 1979	5

(9) MEDICAL SCHOOL: Use precise name and list all schools attended

690-010

Schools Attended	Location (exact address)	Dates Attended (month and year)	No. School Years
UNIVERSITY OF IBADAN COLLEGE OF MEDICINE	IBADAN NIGERIA	JUNE 1982 JUNE 1987	5

(9.1) CLINICAL CLERKSHIPS: Refers to that period of medical education in the clinical disciplines during which as a medical student you gained practical experience in hospitals or clinics.

List clerkships (rotations, pre-graduate internships) for each clinical discipline.

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
MEDICINE	SPECIALIST HOSPITAL BENIN CITY	NIGERIA	DR OKUNKA	MAR 1988 - JUNE 19
SURGERY			MR IDIAKHOA	SEPT 1988 - DEC 19
PAEDIATRICS			DR ASEMOTA	DEC 1987 MAR 198
OBSTETRICS			DR ODEGBA	JUNE 198 - SEPT 19
GYNAECOLOGY				

If additional lines are necessary use the reverse side of Part C.

(9.2) MEDICAL DEGREE: Conferred or Expected

Title of Degree: MBBS Date Conferred /Expected: 1987

(10) MEDICAL LICENSURE: Present or Future

Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine: YES Country or state in which you are licensed: NIGERIA

(11) HOSPITAL TRAINING: Residency or fellowship

Hospitals	Position(s)	Dates

(11.1) EMPLOYMENT: Present employment only

Institution/Company	Position	Dates
Name: MARYLAND MED LABORATORY	Phlebotomist	1992
Street: 1901 Sulphur Spring Road BOX 18290		
City/State/Country: Baltimore MD 21227		

(12) BIRTHDATE/ BIRTHPLACE:

Day/Month/Year: 17 - 4 - 67 Location: ILE-IFE. OSHUN. NIGERIA (City, Province, Country)

(13) SEX: Please check one: ✓ Male ___ Female

(14) NATIVE LANGUAGE: YORUBA

(15) CITIZENSHIP: (Complete all three)

A. AT BIRTH USA ☐ Other ☐ (Specify) NIGERIAN CO6

B. UPON ENTERING MEDICAL SCHOOL USA ☐ Other ☐ (Specify) NIGERIAN

C. NOW USA ☐ Other ☐ (Specify) NIGERIAN

PART C

Students and graduates must sign the application in the presence of their Med. School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) *and* must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.

Seal, stamp or signature of official *must cover a portion of the attached photograph.*

(16) CERTIFICATION BY APPLICANT

I hereby certify that the information given in this application is true and accurate to the best of my knowledge, and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition of the ECFMG Information Booklet for FMGEMS and am aware of its contents.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action.

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any Federal, State, or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

(Must be completed in English)

Signature of Applicant X I Jerrase
(in Latin Characters)

(16.1) CERTIFICATION BY MEDICAL SCHOOL OFFICIAL

A. I hereby certify that the photograph, signature, and information entered on this form accurately apply to the individual named above.

X _____
Signature of Medical School Official

_____ _____ _____
Official Title Date Institution

OR

NOTARIZATION WITH EXPLANATION (Pertains to graduates only)

B. Subscribed and sworn to before me this 31 day of March, 19 92.

X Linda R. Richter Notary Public
Signature of Consular Official, First Class Magistrate, Notary Public Official Title

B.1 **Explain below** why the application form could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

338/I/D

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APR - 6 1992
ECFMG

LINDA R. RICHTER
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires September 2, 1994

482-700

(17) Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked? ☐ Yes ☐ No

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

TO BE USED AS CONTINUATION OF SECTION 9.1 IN PART B